INSURE TENNESSEE
FREQUENTLY ASKED QUESTIONS

General

1. **Doesn't Medicaid already provide health insurance coverage for the poor?**
    a. Every state's Medicaid program is different. Tennessee's Medicaid program, known as TennCare, primarily covers the disabled, pregnant women, children, and caretaker relatives of young children. Someone who earns less than the Federal Poverty Level wouldn't necessarily qualify for TennCare.

2. **Who did the Affordable Care Act seek to cover?**
    a. The Affordable Care Act sought to ensure coverage for individuals up to 400 percent of poverty. One of the ways it intended to do so was by requiring states to expand their Medicaid programs to cover all individuals below 138 percent of poverty (regardless of whether they qualify under an existing category).

3. **Why does Tennessee have a decision to make?**
    a. In 2012, the United States Supreme Court ruled that the federal government could not force states to expand their Medicaid programs, but it left in place the rest of the Affordable Care Act. Therefore, some individuals up to 400 percent of poverty would be able to receive subsidized coverage through the insurance marketplaces, but there would be a gap for those under 100 percent of poverty if a state chose not to expand. Moreover, the planned cuts to uncompensated care payments to hospitals (because they would no longer be needed if everyone had health insurance) would still take effect even if a state chose not to cover those individuals the Act had contemplated would be covered by Medicaid.

4. **How did Governor Haslam reach a decision?**
    a. In March of 2013, Governor Haslam came before a joint convention of the General Assembly and said he would not expand our traditional Medicaid program. He believes that the Affordable Care Act was the wrong approach to solving our country's healthcare challenges, at least in part because it focused solely on ensuring health insurance coverage without addressing cost or outcomes. However, the reality of the Supreme Court's decision was that the components of the law that still took effect would result in our hospitals receiving less money for uncompensated care, and it would create a coverage gap for the working poor who don't qualify for subsidies and cannot otherwise afford insurance. Therefore, he committed to pursuing a third way for Tennessee – a Tennessee Plan.

    After 21 months of hard work and negotiations, Governor Haslam announced an alternative approach called "Insure Tennessee" as a two year pilot that has received verbal approval from the U.S. Department of Health and Human Services and that will be discussed during an extraordinary session of the General Assembly set to begin February 2nd.

Insure Tennessee - Basics

1. **Who are the individuals that qualify for Insure Tennessee?**
    a. They are people between the ages of 19 and 64 who are not otherwise eligible for Medicaid. Their incomes must not exceed 138% of poverty, which means that the most an individual can earn is about $16,000 per year, or $8 per hour. Many, if not most, people in this income group will, of course, have lower incomes. This group is sometimes called the "working poor."

2. **Can't this population get health insurance elsewhere (e.g., Federal Facilitated Marketplace, their employers, etc.)?**
    a. As of today, before the implementation of Insure Tennessee**,** those with incomes between 100% and 138% of poverty can get subsidized insurance through the Federally Facilitated Marketplace. Those with incomes below 100% of poverty and who do not fit into one of TennCare's existing program areas would not qualify for assistance. Even with subsidies, however, Marketplace insurance may be more than a very low income individual can afford.

    Some members of this population who are working may have the opportunity to buy insurance from their employers. The average worker contribution to employer-sponsored coverage in the region is over $1,100 annually. Most workers face additional out-of-pocket expenses when they use health services. For example, the average annual deductible for employer plans nationally is around $1,200 in 2014. Low income Tennesseans may be unable to afford these expenses without assistance.

3. **How is Insure Tennessee different from Medicaid expansion?**
    a. Under traditional Medicaid expansion, a state would simply add eligible individuals to its Medicaid rolls. However, newly eligible adults under Insure Tennessee will not have the option of signing up for TennCare. Those ages 19 and 20 are considered children for Medicaid purposes and thus will be enrolled in the existing program, but all others (adults age 21-64) will only have the option of signing up for one of two new, consumer-driven plans. The Volunteer Plan will help individuals purchase private Employer Sponsored Insurance (ESI), and the Healthy Incentives Plan features accounts similar to Health Reimbursement Accounts that individuals can use to earn rewards for healthy behaviors and that they can tap to pay required premiums and co-pays.

    Moreover, Insure Tennessee has grown out of the state's payment and delivery system reform initiative, which was launched by Governor Bill Haslam in 2013 to shift health care spending toward paying for value rather than paying for volume. This initiative creates financial incentives for providers to furnish high quality care in an efficient and appropriate manner so as to reduce costs and improve health outcomes. Recently Tennessee was awarded a $65 million State Innovation Models grant from the Centers for Medicare and Medicaid Services to further support the goal of making health care in Tennessee a value-based system focused on efficiency, quality of care, and the patient experience.

Volunteer Plan

1. **How will the Volunteer Plan work?**
    a. The state will make available a "defined contribution" to support an eligible employee's participation in an ESI plan. The defined contribution will first be used to cover the employee share of the premium. Remaining funds after payment of the premium will be available to offset other employee cost sharing associated with the plan, including deductibles and co-pays. Any expenses that are beyond the amount of the defined contribution will be the responsibility of the employee.

2. **Will the Volunteer Plan have a definition of what constitutes "employment"?**
    a. No. The critical factor for the Volunteer Plan is whether the individual has access to ESI that meets certain requirements. The Volunteer Plan is only an option for employees who would otherwise be eligible to purchase insurance through an ESI plan and whose employer contributes at least 50% of the cost of the premium.

3. **Will there be a financial impact on employers?**
    a. For employers offering ESI, assumptions regarding employee participation in ESI are likely a routine component of the budgeting process. To the extent such an employer currently employs individuals with incomes below 138% of the federal poverty level who are not eligible for Medicaid and who do not participate in the ESI plan, the employer may or may not choose to alter their budgeting assumptions regarding employee participation in ESI as a result of the existence of Insure Tennessee.

    It is not possible to predict the effect on any given employer, because it will vary. Employee participation could increase; premiums could be reduced as a result of greater employee participation and/or participation of younger employees; Affordable Care Act employer penalties may be avoided as a result of fewer employees purchasing insurance through the Marketplace. The results will depend on the specific characteristics of the employer and its workforce and the choices made by eligible employees.

4. **How will the state determine the amount of the voucher?**
    a. In order to ensure cost-effectiveness, the defined contribution plus any other expenditures the state makes for the individual will always be lower than the average per-person expenditure in the Healthy Incentives Program (described below) for individuals with similar characteristics. TennCare benefits not covered by the ESI will not be "wrapped" or added for Volunteer Plan participants, since enrollees have their choice of plans.

Healthy Incentives Plan

1. **How will the Healthy Incentives Plan work?**
    a. The second option for "Newly Eligibles" ages 21-64 is the Healthy Incentives Plan. Members with incomes that exceed the federal poverty level (approximately $1,000 per month for an individual, and $2,000 per month for a family of four) will be required to pay premiums and copays on certain services. The copays will apply to inpatient admissions, outpatient services, and non-emergency use of the Emergency Department. In addition, there are pharmacy copays that are applicable to persons at all income levels.

    An innovative new feature of the Healthy Incentives Plan is the HIT (Healthy Incentives for Tennesseans) Account. Each member will have a HIT account with a certain amount of credits to which he may add by undertaking healthy behaviors. The member can then use the credits in his HIT account to assist him in paying his premiums and copays. One purpose of the HIT account is to incentivize the enrollee to develop behaviors that will not only improve his health but will also lead to reduced health care costs. Another purpose is to prepare the enrollee for the transition to private insurance that will occur when his income increases.

2. **Are the co-pays and premiums in the Healthy Incentives Plan enforceable?**
    a. Co-pays and premiums are enforceable when the individual involved has an income that is above the poverty level. The term "enforceable" has a different meaning for premiums versus co-pays. An individual who does not pay his premiums for 60 days or more may be disenrolled from the program. A provider may deny services to an enrollee who does not pay his co-pays.

3. **How will those participating in the Healthy Incentives Plan earn dollars for the HIT account?**
    a. Enrollees in the HIT program will earn dollars by engaging in certain healthy behaviors and/or appropriate use of health care services. Some examples might include completing an annual health risk assessment, participating in a disease management program, or refraining from using the emergency room for non-emergency services.

Funding

1. **What will the cost be to Tennessee taxpayers?**
    a. There will be no additional cost to Tennessee taxpayers. The federal government provides an enhanced match rate to states to cover this population, and Tennessee hospitals have committed to cover any state costs that go beyond what the federal government funds. Furthermore, Tennesseans are already paying taxes through the Affordable Care Act, and covering this population will allow us to bring some of those dollars back into the state.

2. **When the "hospitals" committed to finance any state cost in the coming years, did all Tennessee hospitals make that commitment, or was it only members of the Tennessee Hospital Association?**
    a. Several different hospital associations as well as non-member hospitals have stated their commitment to financing Insure Tennessee in the coming years.

3. **Will this be funded by patient receipts at hospitals?**
    a. The hospitals intend to utilize the existing assessment, which is levied against hospital total gross receipts. The existing law states, "A covered hospital may not increase charges or add a surcharge based on or as a result of the annual coverage assessment."

4. **What happens if the federal government changes the match rate or the law regarding provider assessments or if the hospitals back out of their commitment to pay any state cost?**
    a. If the federal funding commitment decreases from what is currently described in the Affordable Care Act or if the hospitals fail to cover the state share of expenses, the Insure Tennessee program will end. This was a part of the verbal agreement with both the federal government and the hospitals, and it is written clearly into the waiver amendment proposing Insure Tennessee.

<u>Miscellaneous</u>

1. **What does the two year pilot program mean?**
    a. Establishing Insure Tennessee as a two year pilot program sets the clear expectation that we will evaluate the program at a specified point in time to assure it is meeting our objectives and is expected to be financially sustainable into the future. Although funding triggers are defined in the waiver request that would result in termination of the program, designing the program as a two year pilot is indicative of a commitment to assess the impact and projected future of the program even if there has been no change in federal or hospital funding commitments.

2. **Isn't TennCare experiencing challenges with its existing eligibility system? Won't expanding eligibility to a new population just exacerbate the problem?**
    a. The state is working tirelessly to address the issues facing eligibility in TennCare. We have implemented work-arounds for all of the identified problems and we have processes in place to quickly address any new issues if they are to arise. Compared to current TennCare populations, the eligibility criteria for Insure Tennessee are fairly straightforward.